**CLAIM FORM NO.CIRB 1**

**CLAIMANT S STATEMENT FOR CIRB**

Policy No : Divisional Office Branch
Name of the Life Assured :
Address of the Life Assured :
Telephone number of the Life Assured :

_____

**PART 1**

**EMPLOYMENT DETAILS**
Employer s name :
Employer s address :
Employer s Telephone Number :
Date of leaving employment, if any

_____

**PART 2**

**INFORMATION ON OTHER CI POLICIES AND MEDICLAIM POLICIES**
Policy number/s
Sum/s assured
Name of the company/companies :
Company address/es :

_____

**PART 3**

**INFORMATION ON ILLNESS**
Illness diagnosed:
Date of diagnosis
Usual Medical Attendant s name address and telephone number

**PART 4**

Please provide the following original documents:
1. Original Policy document
2. Information and reports that shall be indicated by
LIFE INSURANCE CORPORATION OF INDIA for processing the claim

**PART 5**

**DECLARATION**

I, _____ do hereby declare that this statement made hereinabove is true.
I authorise the Hospital/s and Doctor/s who have examined or treated me for any ailment or illness and my employer or its officers or any other person to provide information regarding my illness which they may have acquired before or after the policy was issued by the LIFE INSURANCE CORPORATION OF INDIA to the company or its officers.

I agree to provide information and reports to LIFE INSURANCE CORPORATION for processing the critical illness claim.

Declared at _____

Signature _____ or thumb impression

Name of claimant (in block letters)

Date :

**WITNESS (PERSONS AUTHORISED AS PER LIC NORMS. Please indicate the titles of persons eg Advocate, Bank Manager, Gazette officer, Magistrate, head of village, etc..)**

Signature of witness :

Name of witness :

Designation

Address

Telephone number:

Date :

If the signature of the claimant is in vernacular or thumb impression, the witness should also sign the following declaration.

I certify that I have explained the contents of this form to the claimant in _____language and he/she has affixed his/her signature/thumb impression after fully understanding the same.

Signature of the witness:

I agree to provide information and reports to LIFE INSURANCE CORPORATION for processing the critical illness claim.

Declared at _____
Signature _____ or thumb impression
Name of claimant (in block letters)

Date :

**WITNESS (PERSONS AUTHORISED AS PER LIC NORMS. Please indicate the titles of persons eg Advocate, Bank Manager, Gazette officer, Magistrate, head of village, etc..)**

Signature of witness :
Name of witness :
Designation
Address
Telephone number:
Date :

If the signature of the claimant is in vernacular or thumb impression, the witness should also sign the following declaration.

I certify that I have explained the contents of this form to the claimant in _____language and he/she has affixed his/her signature/thumb impression after fully understanding the same.

Signature of the witness: